SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Upload of NDIS Hospital Discharge Report into the Patient Electronic Medical Record (eMR) and Release of Information
TYPE OF DOCUMENT	Procedure
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DATE OF PUBLICATION	May 2025
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LEVEL OF EVIDENCE	National Standards for Safety and Quality in Healthcare: Standard 5 - Comprehensive Care
REVIEW DATE	May 2030
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records & Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-chairs of the Health Records Committee Leonie.Patterson@health.nsw.gov.au Antony.Sara@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Records Management – Health
KEY TERMS	Electronic Medical Record, eMR, upload, National Disability Insurance Scheme, NDIS, Hospital Discharge Report
SUMMARY	The NDIS Hospital Discharge Report includes important health information and forms part of the patient's medical record. This procedure provides guidance for SESLHD staff on the process to import completed NDIS Hospital Discharge Reports into the electronic medical record. It also provides guidance on their release if requested.

1. POLICY STATEMENT

This procedure applies to all SESLHD clinical staff that submit NDIS Hospital Discharge Reports to the National Disability Insurance Agency (NDIA).

The NDIS Hospital Discharge Report includes important health information and forms part of the medical record. Importing the document into the patient's electronic health record (eMR) ensures that it is stored and available for ongoing care management.

This procedure provides guidance for SESLHD clinical staff on the process to import completed NDIS Hospital Discharge Reports into the electronic medical record. It also provides guidance on their release if requested.

2. BACKGROUND

A NDIS Hospital Discharge Report (HDR) is completed by the multidisciplinary team to support the safe and timely discharge of NDIS participants. The report outlines the findings of clinical assessments and provides information to help the NDIA understand the participant's needs upon discharge, such as personal care, daily living supports, and assistive technology.

The final HDR is submitted by the healthcare team to the SESLHD Disability Strategy Unit who submit it to the NDIA as per the SESLHD NDIS Hospital Discharge Escalation Pathway. The report also forms part of the health record and should be sent to the relevant Health / Medical Record Department by email for importing into the eMR.

3. DEFINITIONS

NDIS Hospital Discharge Report (HDR): This report provides the National Disability Insurance Agency (NDIA) with information regarding clinical observations that describe a person's functional profile while in hospital

4. RESPONSIBILITIES

4.1 Employees will:

- Ensure that HDR's are forwarded to the appropriate Health Information / Records Department.
- Follow the procedure below.

4.2 Line Managers will:

- Ensure staff are aware of and monitor compliance with the procedure.
- Support staff to follow the procedure

4.3 District Managers/ Service Managers will:

- Support staff to follow the procedure.

4.4 Health Information/ Records Managers will:

- Ensure that processes are in place to import the HDR into the eMR.
- Monitor and audit the importing process as per this procedure.
- Oversee the release of information for requests for the HDR.

5. PROCEDURE

5.1 Multidisciplinary team:

- Confirm the document type and title is clear and correct - 'NDIS Hospital Discharge Report' (Appendix 1).
- The HDR must include four identifiers: Given name and Family Name, MRN, DOB and sex on the top right-hand corner of every page.
- The HDR must include the clinicians name, signature and date of encounter.
- The approved document must be scanned as a PDF by administrative / clinical staff as determined by Department Head and sent by email to the relevant Health Information / Record Department email address (see table below).
- The HDR is emailed to the Disability Strategy Unit for escalation to the NDIA.

Site / Facility	Email address
Prince of Wales Hospital and Royal Hospital for Women	SESLHD-HealthInformationPOWH@health.nsw.gov.au
St George Hospital	SESLHD-STG-ClinicalInformation@health.nsw.gov.au
Sydney / Sydney Eye Hospital	SESLHD-SSEH-ClinicalInformation@health.nsw.gov.au
The Sutherland Hospital	SESLHD-TSH-ClinicalInformation@health.nsw.gov.au
War Memorial Hospital	SESLHD-HealthInformationWMH@health.nsw.gov.au
Calvary Health Care Kogarah	CHC-Kogarah-MedicalRecords@health.nsw.gov.au
Disability Strategy Unit	SESLHD-NDIS@health.nsw.gov.au

5.2 Health Information / Record Department - Importing:

- To ensure the document is determined as complete for acceptance to the medical record (see 5.1 above).
- The Health Information Unit / Health Record Manager or designated staff will import the emailed document into the patient's eMR against the appropriate encounter and document type of 'NDIS Hospital Discharge Report'.

5.3 Health Information / Record Department – Release of Information:

- HDR is **NOT** to be released by Health Information / Medical Record Department as part of regular ROI requests from patient or third party.
- HDR to be released if records are required for subpoena, Ombudsman investigation, HCCC inquiry, Coroner's case, any internal review or legal proceedings.
- HDR may be released to the patient when explicitly requested using eMR QRG: Printing a Single Document with Medical Record Request. No fee should be raised.
- To support the above, the HDR will only be available in Report Request (XR) within the "Full Medical Records Template - Encounter Summary" and "Full Medical Records Template XR".

6. DOCUMENTATION

Not required.

7. AUDIT

Monthly auditing will be attended by the SESLHD Medical Record Managers to:

- Monitor numbers of documents uploaded
- Ensure documents are uploaded to the correct patient, encounter and note type.

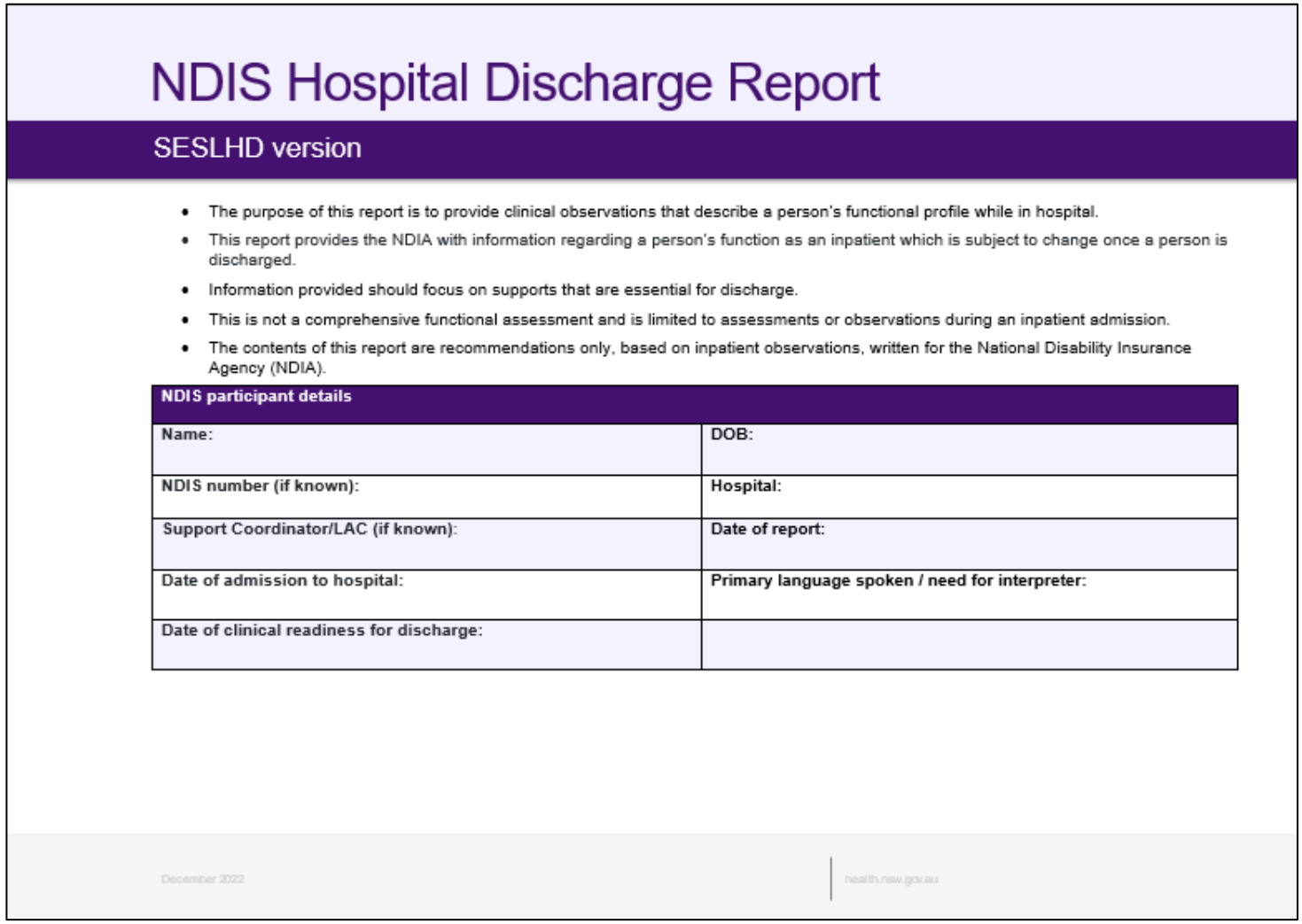
8. REFERENCES

- *Health Records and Information Privacy Act 2002* (NSW)
- NSW Health Policy Directive PD2012_069 - Health Care Records - Documentation and Management
- SESLHDPR/292 - Hybrid HealthCare Record
- Printing a Single Document with Medical Record Request

9. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
May 2025	1.0	New procedure. Endorsed by SESLHD Health Records and Medico-Legal Committee. Approved by SESLHD Patient Safety and Quality Committee.

APPENDIX 1 – NDIS Hospital Discharge Report template



NDIS Hospital Discharge Report

SESLHD version

- The purpose of this report is to provide clinical observations that describe a person's functional profile while in hospital.
- This report provides the NDIA with information regarding a person's function as an inpatient which is subject to change once a person is discharged.
- Information provided should focus on supports that are essential for discharge.
- This is not a comprehensive functional assessment and is limited to assessments or observations during an inpatient admission.
- The contents of this report are recommendations only, based on inpatient observations, written for the National Disability Insurance Agency (NDIA).

NDIS participant details	
Name:	DOB:
NDIS number (if known):	Hospital:
Support Coordinator/LAC (if known):	Date of report:
Date of admission to hospital:	Primary language spoken / need for interpreter:
Date of clinical readiness for discharge:	

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Participant clinical information	
Disability	
Previous disability background and related medical history	
Social and living situation prior to hospitalisation	
Discharge destination	
How does the Disability impact function?	Physical:
	Cognitive:
	Behavioural:
	Speech and Language:
	Psychological:

Participant functional information observed as an inpatient.

Appropriate multidisciplinary team members to assess the participant's ability to perform functional tasks through observation in real or simulated tasks in the functional capacity tasks domains.

Task	Type of assistance/ supervision	Level of assistance	Assistive technology required (N/A if not needed)	Reason for assistance
Bed mobility	Choose an item.	Choose an item.		
Bed transfers	Choose an item.	Choose an item.		
Chair transfers	Choose an item.	Choose an item.		
Toilet transfers	Choose an item.	Choose an item.		
Car transfers	Choose an item.	Choose an item.		
Indoor walking	Choose an item.	Choose an item.		
Outdoor walking	Choose an item.	Choose an item.		
Wheelchair use	Choose an item.	Choose an item.		
Communication	Choose an item.	Choose an item.		
Toileting	Choose an item.	Choose an item.		
Continence (bladder)	Choose an item.	Choose an item.		
Continence (bowel)	Choose an item.	Choose an item.		

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Showering	Choose an item.	Choose an item.		
Dressing	Choose an item.	Choose an item.		
Grooming	Choose an item.	Choose an item.		
Eating / drinking	Choose an item.	Choose an item.		
Sleeping	Choose an item.	Choose an item.		
Pressure area care	Choose an item.	Choose an item.		
Respiratory supports	Choose an item.	Choose an item.		
Behaviour management	Choose an item.	Choose an item.		
Cooking	Choose an item.	Choose an item.		
Cleaning	Choose an item.	Choose an item.		
Lawn maintenance / gardening	Choose an item.	Choose an item.		
Laundry	Choose an item.	Choose an item.		
Medication	Choose an item.	Choose an item.		
Finances	Choose an item.	Choose an item.		
Shopping	Choose an item.	Choose an item.		

Transport	Choose an item.	Choose an item.		
Home security	Choose an item.	Choose an item.		
Safety/phone use	Choose an item.	Choose an item.		
Decision making	Choose an item.	Choose an item.		
Social & Community access	Choose an item.	Choose an item.		

Participant daily care requirements as an inpatient.

Time of day	Inpatient Routine	Time Taken (In inpatient setting)	Frequency (How many times support required per day in inpatient setting)
Morning care		Choose an item.	
		Choose an item.	
		Choose an item.	
		Choose an item.	
Afternoon		Choose an item.	
		Choose an item.	
		Choose an item.	
		Choose an item.	
Evening		Choose an item.	
		Choose an item.	
		Choose an item.	
		Choose an item.	

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Overnight care		Choose an item.	
		Choose an item.	
Weekly care		Choose an item.	
		Choose an item.	
		Choose an item.	
		Choose an item.	

Additional assessments	
Other assessments and tools	

Only use "physical environment requirements" section if applying for home modifications or Specialist Disability Accommodation (SDA) otherwise delete or leave blank.

Physical environment requirements	
Accessible features	e.g., ___ uses a manual wheelchair for mobility therefore needs flat/ramp access in and out of their environment. e.g., ___ uses a commode for toileting and showering therefore needs flat entry to access the bathroom and toilet (if separate) as well as flat access into the shower with no screen *For a person needing modifications to their existing home* DELETE ROW IF NOT RELEVANT
Improved livability (SDA)	*For a person needing sensory features to manage visual/cognitive impairments etc.*
Robust (SDA)	*For a person with complex behaviours needing reinforcement to walls and surfaces*
Fully accessible (SDA)	*For a person needing to use a manual or power drive wheelchair indoors with specific bench heights etc.*

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Physical environment requirements	
High physical support (SDA)	*For a person needing a ceiling hoist or wider hallways for bariatric needs etc.*

Capital and Consumables Recommendations		
Item	Justification for specialist AT (that hasn't been addressed above)	Estimated cost/quote/script

Capacity Building Supports Recommendations	
Support that enables the participant to implement **the goals** outlined in their NDIS discharge plan (essential for discharge).	
Support Coordination	*For e.g. assistance with NDIS plan implementation*
Improved daily Living	*For e.g. Mealtime management plan (to be completed in their living environment on discharge)*
Improved relationships	*For e.g. Behaviour support plan (to be completed in their environment on discharge)*

Participants preferred plan management option.	
Identify participant's preferred plan management option and give reason	☐ Agency managed ☐ Self-managed: the participant wishes to manage their own budget and/or use unregistered providers ☐ Plan managed: the participant wishes to use unregistered providers but does not want to manage their budget ☐ Does not have a preference

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Additional information
ONLY INCLUDE INFORMATION THAT IMPACTS DISCHARGE OR IS CONSIDERED ESSENTIAL FOR DISCHARGE.

Attachments

Clinician details	
Name: Designation:	Ph: E:
Name: Designation:	Ph: E:
Name: Designation:	Ph: E: